Appendix 2: teaching with the Balint approach – a personal view from a Balint course organiser

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When I read the report of our research, I have no difficulty in recognising the kind of group sessions described in the case studies. They are very similar in style to the Balint group sessions that I have also conducted with GP registrar and SHO groups. I recognise the disparity between the aims of the leaders and the somewhat different agenda of the group members. They are not like the doctors in ongoing groups or weekend groups. Established GPs who join a Balint group or come to a weekend meeting are there because they want to be in a traditional Balint group. Some have enjoyed the experience in a previous group and want to do more; others may be curious about the method and want to sample it. For some it may seem vital nourishment, renewing the strength they need to cope with their everyday work.

The junior doctors in VTS, on the other hand, have not signed up to do Balint. They have had Balint thrust upon them by enthusiastic course organisers. I am not sure how much explanation they receive at the beginning about what the group leaders have in store for them. I feel guilty about not being more open with my own group. I suppose I am afraid of turning them off if I am too prescriptive. On the other hand I also remind myself that they are not volunteers, and that they may have other concerns; why shouldn't they have some control over what the group does and where it goes?

Perhaps, like my group, the Highville doctors are introduced to Balint along these lines:

> *We are going to sit in a circle and I shall invite anyone who wants to, to tell us about a patient who has been a worry or a puzzle or of interest or for some reason remains on your mind. In this kind of group we are particularly interested in the doctor–patient relationship and the feelings that doctor and patient have for each other. These feelings can be very powerful and disruptive. Although you may feel more worried at this stage about your lack of clinical knowledge, we think that you will find that, in practice, it is these emotional factors between doctor and patient that cause the most difficulty. We think it is helpful to look at our own feelings because they may reflect what the patient is feeling. If you feel sad it may be because he or she is depressed. So examining how the patient makes you feel can be a useful diagnostic tool. Any questions? OK. So who has a case?*

This is the kind of speech I make to introduce my own group to our Balint work. But when they start to present cases, they forget my introduction because their own concerns are more pressing. Usually they present patients who have given them a hard time and made them feel bruised, or patients who illustrate a dilemma, medical, ethical, cultural, procedural. 'Other people may have had this sort of problem too. I discussed it with my trainer and I'd like to know what you all think.'

So the doctors use the group to let off steam, relieve injured feelings, gain sympathy and support, canvas opinions and air their views about all sorts of matters. Meanwhile the leaders are pleased that they are talking, using and enjoying the experience, getting to know each other, helping each other. But is it Balint? Not really. It's what Balint groups frequently do when they are doing what we old-fashioned Balint doctors call 'avoiding the work'.

The leaders can be seen in the case studies to be trying to get the group back to 'work'. Work is not just about how you feel, but what that might tell you about the patient's feelings: just that one patient, a unique individual. Work is about trying to help that patient as well as recognising and expressing your own feelings. The somewhat derided 'speculation' that the leaders strive to encourage is about trying to understand why the patient has come, how he or she feels about the doctor, what sort of doctor he or she wants, what makes him or her behave the way he or she does. Balint work encourages imaginative reflection but it is also very focused. Even volunteer groups stray from the work when it gets painful. Patients' pain is disturbing if you let yourself feel it; more so if you have known that kind of pain too. So when the group members seem to be in flight from the feelings, the leaders intervene, now and then, to get them back on track.

Groups for general practitioner SHOs and registrars, on the other hand, avoid 'true Balint work' most of the time. It's difficult to work out how far you can intervene without making them feel they are being prevented from having a free discussion. As a leader, I just hope that as time goes on they will get the point and spend more group time on 'proper' Balint work. Some groups and some individuals do. We old-fashioned Balint doctors believe that this is a kind of emotional education that equips you to deal with feelings in a way that helps patients as well as doctors.

If VTS don't want to have traditional Balint groups, does it matter? This research has clearly shown how beneficial the group can be as a learning experience in all sorts of ways. A good deal of self-knowledge can be gained. There is a wonderful opportunity to exchange ideas and feelings with colleagues, and try to make some sense of the world of general practice, a world so different from hospital medicine, so dangerous, so exciting, so potentially fulfilling.

Does it matter if our Balint groups include relatively little of that focused work on the doctor–patient emotional

transaction? Is a more free-floating discussion to be preferred as more relevant? I suspect that, as we say elsewhere in this paper, times have changed and Balint as it exists today has also had to change. I agree that we need to preserve what we can't afford to lose. I just wonder if, in accepting the kind of group we see in the paper, we have already conceded the loss of something very valuable to us: the intense focus on the individual doctor–patient relationship.